



Electronic Health Records:

State Incentives and Usability Across Hospital Settings

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**Prepared for the Maryland General Assembly
House Health & Government Operations Committee**

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Synopsis

State Incentive Program

The State-Regulated Payor Electronic Health Record (EHR) Adoption Incentive program (State incentive program) was established in law in 2009, making Maryland the first state to offer incentives to primary care physician practices to adopt and implement EHR systems.¹ The State incentive program was implemented in October 2011 through regulation and aims to promote the adoption and use of EHRs among primary care physician practices. However, the State incentive program is not spurring the level of EHR adoption and use envisioned by the law and needs to be retooled. While approximately 50 percent of primary care physicians have adopted an EHR, only about four percent of Maryland's eligible primary care physician practices had received an incentive payment, as of April 2013.² The performance of the State incentive program trails significantly when compared to the participation in the Centers for Medicare & Medicaid Services' (CMS) Medicare and Medicaid EHR Incentive Program (federal incentive program), where approximately 29 percent of Maryland's eligible primary care physician practices have received a federal incentive program payments.^{3, 4, 5, 6} The State incentive program as it is currently configured is largely aimed at accelerating EHR adoption, whereas the federal incentive program provides incentives for both the adoption and meaningful use of EHRs, which may account for some of the differences seen in the program uptake.

In the summer of 2013, leadership from the General Assembly's Maryland House Health & Government Operations (HGO) Committee requested that the Maryland Health Care Commission (MHCC) evaluate the State incentive program and determine if changes are necessary to ensure the intent of the law continues to be met. In collaboration with the State incentive program workgroup (workgroup), MHCC determined that alignment of the State incentive program with the federal incentive program is necessary going forward.⁷ This will ensure that the State's EHR adoption incentives are appropriately aimed at improving care delivery as opposed to buying technology. Aligning the State incentive program with the federal incentive program also establishes consistencies around practice requirements for participation in both incentive programs. Restructuring the State incentive program is expected to increase EHR adoption and reduce administrative program challenges for payors and providers.⁸ While stakeholder viewpoints differ

¹ See Appendix A for Md. Code Ann., Health-Gen. § 19-143.

² See Appendix B for State incentive program payment information by payor.

³ See Appendix C for State and federal incentive program participation status among Maryland eligible primary care practices.

⁴ CMS Individual Medicare and Medicaid Payment Data for Maryland, April 2013.

⁵ Maryland eligible primary care practices were determined using the 2011-2012 Maryland Board of Physicians Licensure File, which is a database of physician responses to the bi-annual licensure survey.

⁶ The federal incentive program as detailed within 42 C.F.R. § 142, 143, 422, et. al. (2010).

⁷ Workgroup participants included representatives from: State-Regulated payors (Aetna, Inc., CareFirst BlueCross BlueShield, CIGNA Health Care Mid-Atlantic Region, Coventry Health Care, Kaiser Permanente, UnitedHealthcare, MidAtlantic Region); MedChi, The Maryland State Medical Society; the Maryland Department of Health and Mental Hygiene; the Maryland Hospital Association; and the State-Designated health information exchange, Chesapeake Regional Information System for our Patients.

⁸ Many practices raised concerns regarding the two-step process that spans nine months from application to payment, and in generating the patient attribution list used by payors to calculate the incentive amount.

slightly on the actual revisions that should be made to the State incentive program, the workgroup generally agreed that the proposed changes represent a balanced approach for stakeholders that will further increase primary care physician practice participation.

Recommendations

- Change eligibility requirements to allow primary care physician practices to qualify for an incentive payment if they adopt a certified EHR system and meet one of the following criteria at the time the provider submits a request for an incentive: one or more physicians within the practice have attested to the current Stage of Meaningful Use (MU); or a primary care physician practice participates in any MHCC approved Patient Centered Medical Home (PCMH) program and achieves National Committee for Quality Assurance (NCQA) PCMH recognition.^{9, 10, 11, 12, 13}
- Streamline the administration of the State incentive program application and payment process.
- Clarify the definition of a primary care physician practice eligible for an incentive payment.
- Extend the sunset date by two years to December 31, 2016, and assess the impact of the State incentive program in 2015.

Hospital EHR Usability

Many providers practice in multiple hospitals with different EHR systems, requiring providers to learn new systems and utilize them correctly so that patient care is not negatively impacted. Variability in EHR systems among acute care hospitals creates challenges for hospital providers using the technologies deployed in multiple hospitals. As part of the HGO Committee's request, MHCC was also asked to explore hospital provider challenges involving the usability of EHR systems across acute care hospital settings, post adoption. Through interviews with hospital leaders and providers, the following EHR usability challenges were consistently identified: initial hospital EHR adoption transitions and training; non-employed providers with hospital privileges that utilize the hospital's system infrequently; and data fragmentation within the hospital system that causes the need to use multiple systems. Usability challenges pertaining to the lack of industry standards on look and feel of EHRs span across states and require policy interventions at the national level to resolve; these discussions are currently underway.

⁹ In coordination with the workgroup, MHCC is evaluating the adoption of either NCQA PCMH Level Three recognition or Level Two recognition for inclusion in draft proposed regulation language. At the time of this report, a final decision has not been made.

¹⁰ CMS Final Rules set forth in 42 CFR Parts 412, et al. specify the initial criteria that providers must meet in their use of an EHR system in order to qualify for the federal incentive payment, generally referred to as MU.

¹¹ More information about PCMH and NCAQ recognition is available at:
<http://www.ncqa.org/portals/0/PCMH%20brochure-web.pdf>.

¹² NCQA levels of PCMH recognition require practices to utilize specific standards and technology to transform their practices. As the recognition level increases, the required use of technology and standards also increases.

¹³ See Appendix D for a summary of NCQA program standards and Appendix E for an NCQA PCMH and Meaningful Use Crosswalk.

A common theme that emerged during the discussions of these challenges relating to hospital usability centered on variation in hospital EHR training curriculums. Stakeholders believed that a standardized training curriculum will help lessen the challenges that providers often experience in using different EHR systems in the acute care hospital environment. Ensuring that users have consistent levels of familiarity with hospital EHR systems before they are used in care delivery will help lessen usability challenges. The MHCC proposes a collaborative effort among acute care hospitals to identify core elements of an EHR training curriculum aimed at promoting uniformity in training across hospitals.

Recommendation

- In collaboration with stakeholders, establish a uniform EHR training curriculum for acute care hospitals to mitigate challenges providers may experience when using varying EHR systems.

Introduction

Increased use of EHRs has the potential to improve patient care and create efficiencies in the health care system. In 2009, Maryland law established a State incentive program that requires payors to offer incentives to primary care physician practices that adopt and use certified EHR technology.¹⁴ During the State incentive program conception, it was anticipated that uptake would be sizable. The current program has not achieved the desired performance that was envisioned in the law. Over the last 18 months, only approximately four percent of eligible primary care physician practices have received State incentive payments from payors.

In 2011, the law that created the State incentive program was amended to require MHCC to study the State incentive program and provide recommendations on whether participation in the program should be extended beyond primary care physician practices. This law also required MHCC to report findings to the General Assembly. In January 2013, MHCC released, *Maryland HB 736, Electronic Health Records – Incentives for Health Care Providers – Regulations*, which concluded that additional time was necessary to adequately evaluate the impact of the State incentive program and propose enhancements.¹⁵

The MHCC reconvened the State incentive program workgroup in June 2013, with representatives from all six participating payors and the following organizations: MedChi, The Maryland State Medical Society; the Maryland Department of Health and Mental Hygiene (DHMH); the Maryland Hospital Association (MHA); and the State-Designated health information exchange (HIE), Chesapeake Regional Information System for our Patients (CRISP). Through a consensus-driven process using the workgroup's input, MHCC has developed recommendations for modifying the State incentive program.

This report, developed at the request of the HGO Committee, provides an update on the State incentive program and proposes recommendations to ensure its continued progress in meeting the

¹⁴ As detailed in Maryland regulations, COMAR 10.25.16, *Electronic Health Record Incentives*, which went into effect in October 2011. See Appendix F for COMAR 10.25.16.

¹⁵ MHCC, *Maryland HB 736, Electronic Health Records – Incentives for Health Care Providers – Regulations*, January 2013. Available at: <http://mhcc.dhmmh.maryland.gov/hit/Documents/hb736.pdf>.

law's intent. Also detailed in this report are provider challenges with EHR usability across acute care hospital settings and a recommendation to mitigate those challenges.

State Incentive Program

Overview

In order to develop regulations to implement the State incentive program with input from the industry, in 2009, MHCC convened a workgroup to assist with developing the framework for the State incentive program. Regulations went into effect in October 2011. The current State incentive program makes available to primary care physician practices a base incentive of \$8 per member, up to \$7,500 per payor for the adoption of a certified EHR system.¹⁶ An additional incentive of up to \$7,500 per payor is available for primary care physician practices that demonstrate advanced use of an EHR.¹⁷ A primary care physician practice submits an application to each payor that covers insured patients of the practice. A payor then issues an acknowledgement letter to the practice within 90 days of receipt. Six months after submitting an application, a practice must submit a request for payment to each payor that includes a list of the payor's insureds that are patients of the practice. The request for payment may be for only the base incentive, but may also include a request for an additional incentive. Payors are required to issue payments within 90 days of receiving the completed requests for payment.

Program Alignment

The State incentive program, as originally conceived, was intended to accelerate EHR adoption and use among primary care physician practices. The payments made by payors through the State incentive program fund the adoption of an EHR system. In contrast, the federal incentive program provides payments to providers who adopt certified EHR systems and use them to improve patient care quality, increase the health of the population, and reduce health care costs. The relatively low participation rate in the State incentive program is somewhat attributed to its misalignment with MU requirements under the federal incentive program, and to the administrative challenges experienced by those seeking a State incentive payment.¹⁸ Aligning the State incentive program with the federal incentive program ensures a consistent strategy for EHR incentives, alleviates administrative challenges, and could accelerate participation in the State incentive program.

EHR Usability Challenges across Hospital Settings

Variability in EHR systems among acute care hospitals creates challenges for providers seeking to use the technologies deployed in multiple hospitals. In general, EHR usability refers to the layout

¹⁶ Both hospital-owned and nonhospital-owned primary care practices are eligible for the program, including: family, general, geriatric, internal medicine, pediatric, and gynecology primary care practice specialties.

¹⁷ Advanced use is defined by each payor, and may include working with a State-Designated Management Service Organization or participating in a payor quality improvement outcomes initiative.

¹⁸ Many practices raised concerns regarding the two-step process that spans nine months from application to payment, and in generating the patient attribution list used by payors to calculate the incentive amount.

and complexity of the screens that a provider uses to enter data into the system.¹⁹ In Maryland, approximately 89 percent of the 46 acute care hospitals have adopted an EHR system.²⁰ EHR systems are typically configured differently by each acute care hospital. To better understand the challenges related to EHR usability across acute care hospital settings, MHCC interviewed hospital Chief Medical Information Officers (CMIOs) and Chief Information Officers (CIOs), providers, and EHR vendors. CMIOs, CIOs, and providers cited the following hospital specific challenges:

- Initial implementation and training hurdles;
- Non-employed specialists with hospital privileges that utilize the hospital's system infrequently; and
- Data fragmentation and the need to use multiple systems.

Most EHR usability challenges are unique to hospitals and require them to establish policies to address the challenges. The MHCC discussions with CMIOs and CIOs brought to light the challenges for users that occur due to variation in EHR training programs. Collaborating with the MHA, CMIOs, and CIOs in developing standards in EHR training is expected to lessen the challenges related to EHR usability.

Many CMIOs and CIOs noted that, for a number of EHR users, the transition to an EHR can cause short term disturbances in routine functions that can extend for a period of time and impact productivity. While some hospitals have in depth training programs and require their employed providers and those with privileges to attend training, not all hospitals have such a program. Additionally, training is most often implemented differently across hospitals and EHR solutions. While some employ online learning modules, others utilize training classes or train-the-trainer programs.²¹ Some interviewees indicated that it is not uncommon for providers to express dissatisfaction with how much time the training takes or that it is not tailored to their specialty or workflows.

Challenges exist for non-employed specialists with hospital privileges that practice in multiple hospital settings; these providers are required to learn several EHR systems. In general, EHR systems are customizable with respect to layout (what the user sees), forms/templates (screens users utilize to enter information), and workflows (the order in which a user enters information) so to the user it is often the same as learning a brand new system. Some hospitals report that EHR training is required as part of the provider privileging and credentialing process, though not all acute care hospitals have such a requirement. Additionally, most hospitals employ staff to assist providers with questions about the EHR system; depending on hospital size, the number of staff available to assist providers varies.

Challenges also exist as it relates to patient information being fragmented and the need to use multiple systems. Providers in a hospital setting rely on a number of systems, including the EHR

¹⁹ Agency for Healthcare Research and Quality, *EHR Usability Toolkit: A Background Report on Usability and Electronic Health Records*, August 2011. Available at: https://www.dchi.duke.edu/publications-1/publications/Johnson-EHR_Usability_Toolkit_Background_Report.pdf.

²⁰ MHCC, *2013 Health Information Technology: An Assessment of Maryland Hospitals*. Available at: http://mhcc.dhmdh.maryland.gov/hit/Documents/2013_hospital_health_it_assessment.pdf.

²¹ Train-the-trainer programs provide training to one or two hospital employees, typically nurses, who then train the remaining hospital staff.

and systems for viewing radiological images, test results, and other specialized clinical information. While some hospitals have integrated the information from these various systems into one system, e.g. the EHR, other hospitals in the State require providers to use multiple systems to access different data elements. Providers practicing in multiple settings may not have access to the same information in each setting. This is perceived as a usability issue by providers, who believe that the goal of the EHR is to make all patient data available at the point of care.

Federal policy initiatives related to EHR usability have not sought to address EHR usability across acute care hospitals. The federal government has only issued rules on the functionality of EHRs that are generally focused on the potential impacts of EHR systems on care delivery and patient safety. The Office of the National Coordinator for Health Information Technology (ONC) has developed a national plan to address patient safety issues caused by health information technology (health IT), including EHR usability in particular.²² The plan details a collaborative effort among ONC, the Agency for Healthcare Research and Quality, the National Institute of Standards and Technology, the Health Information Management Systems Society, Electronic Health Record Association, and various EHR vendors to develop and implement new tools, programs, and policies to ensure that patient safety is not adversely affected as EHR adoption increases.

State Incentive Program Recommended Changes

Changes to the State incentive program are needed to meet the intent of the law. The proposed changes will promote the adoption of EHRs, better align requirements with the federal incentive program, streamline administrative processes for payors and providers, and increase participation. Most workgroup participants generally favored changes that more closely align the State incentive program with their stakeholders' interests. The efforts of the workgroup in collectively coming to consensus around a framework for enhancing the State incentive program are commendable. The following table illustrates the changes to the current State incentive program that are recommended, as well as key requirements that would remain unchanged.

Current Requirements	Recommended Changes
Payors administer the program	No change
Only primary care physician practices are eligible	No change to eligibility; however, the definition of a primary care physician practice would be aligned with CMS specialty codes
Practices must adopt a nationally certified EHR system to receive the base incentive	To receive an incentive payment, a practice must adopt a nationally certified EHR system and either attest to meeting the current MU requirements, or participate in any MHCC

²² More information about the ONC health IT and patient safety initiative is available here: <http://www.healthit.gov/policy-researchers-implementers/health-it-and-patient-safety>.

	approved PCMH program and achieve NCQA PCMH recognition ²³
Practices must meet additional criteria established by each payor to receive the additional incentive of up to \$7,500	Remove the additional incentive
Base incentive amount is \$8 per member per payor, not to exceed \$7,500	Incentive payment amount increased to \$25 per member, not to exceed the existing \$15,000 per practice per payor limit
Practices must submit a list of patients attributed to the practice per payor	Practices would no longer be required to submit the patient list – rules on attribution to be defined in the regulation
No requirement on assessing the program impact	Assess the impact of the program in 2015
Program sunsets on December 31, 2014	Program sunsets on December 31, 2016

State Incentive Program Enhancements

Change eligibility requirements to allow primary care physician practices to qualify for an incentive payment if they adopt a certified EHR system and meet one of the following criteria at the time the provider submits a request for an incentive: one or more physicians within the practice have attested to the current Stage of MU; or a primary care physician practice participates in any MHCC approved PCMH program and achieves NCQA PCMH recognition.²⁴

This recommendation aligns the State incentive program with requirements of the federal incentive program regarding meaningful use of an EHR system. It also includes an option for primary care physician practices to qualify for the State incentive program by meeting NCQA PCMH requirements when they do not meet the eligibility requirements for the federal incentive program.^{25, 26, 27} PCMH programs promote a model of care that emphasizes care coordination and

²³ In coordination with the workgroup, MHCC is evaluating the adoption of either NCQA PCMH Level Three recognition or Level Two recognition for inclusion in draft proposed regulation language. At the time of this report, a final decision has not been made.

²⁴ In coordination with the workgroup, MHCC is evaluating the adoption of either NCQA PCMH Level Three recognition or Level Two recognition for inclusion in draft proposed regulation language. At the time of this report, a final decision has not been made.

²⁵ NCQA defines a PCMH as “a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient’s family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.” <http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH.aspx>.

²⁶ NCQA levels of recognition require practices to utilize specific standards and technology to transform their practices. As the recognition level increases, the required use of technology and standards also increases.

²⁷ Eligible providers for the Medicare incentive program include providers who have at least one Medicare patient and are doctors of medicine, osteopathy, dental surgery, dental medicine, podiatry, optometry, or chiropractors. Eligible providers for the Medicaid incentive program must meet the minimum 30 percent Medicaid patient volume threshold, or 20 percent for pediatricians, and be a Doctor of Medicine or Doctor of

communication with patients to transform primary care physician practices into medical homes. PCMH programs lead to higher health care quality and lower health care costs and can improve patient and provider experiences.²⁸ In general, primary care physician practices that achieve NCQA PCMH recognition are well prepared to qualify for MU and vice versa. While the MHCC considered other practice accreditation programs as a requirement for the State incentive program, NCQA recognition most closely aligned with the requirements under the federal incentive program.

Streamline the administration of the State incentive program application and payment process.

Program administration would remain a function of the participating payors. The application process would be reduced from a two-step process to a one-time incentive payment request. A primary care physician practice would submit a request for payment once it attests to MU or receives NCQA PCMH recognition. Supporting documentation that validates a primary care physician practice's achievement of MU or NCQA PCMH recognition would be required as part of the incentive payment request.

The base and additional incentive payments would be combined into a single incentive payment. A qualifying primary care physician practice would receive an increase in the incentive payment amount from \$8 to \$25 per member and would be eligible to receive a maximum amount of \$15,000 per payor. Payors would continue to calculate the incentive amount based on members assigned to or treated by the practice within the preceding two years. A primary care physician practice would no longer need to submit a patient attribution list with its incentive payment request and could request that a payor provide a member listing that was used in the calculation of the incentive payment.

Clarify the definition of a primary care physician practice eligible for an incentive payment.

The definition of primary care physician practice would be based on the practice's CMS specialty code.²⁹ These national codes are used by providers to indicate their practice type and specialty at the claim level. Qualifying primary care physician practices for the State incentive program include: family; general; geriatric; internal medicine; pediatric; or gynecologic practice. As part of the incentive payment request, a primary care physician practice would be required to include its existing CMS specialty code used in claims submissions.

Extend the sunset date by two years to December 31, 2016, and assess the impact of the State incentive program in 2015.

The State incentive program has been in existence for nearly two years, and its impact on accelerating EHR adoption and use is marginal. Slow growth of the program is attributed to payor and provider challenges around implementation. As of April 2013, payors reported that around 106 of nearly 2,357 eligible primary care physician practices had received a State incentive program payment. In addition, almost 89 percent of primary care physician practices that have received a federal incentive payment have not received a State incentive payment. While payors

Osteopathic Medicine, dentist, nurse practitioner, certified nurse-midwife, or physician assistant working within a federally qualified health center that is led by a physician assistant.

²⁸ *Benefits of Implementing the Primary Care Patient-Centered Medical Home, A review of Cost & Quality Results*, 2012. http://www.pcpcc.org/sites/default/files/media/benefits_of_implementing_the_primary_care_pcmh.pdf.

²⁹ CMS specialty codes are self-designated and describe the kind of medicine the providers practice.

generally support extending the sunset date, they expressed uncertainty about the impact of extending the sunset date on program participation. Payors and MedChi have agreed to bolster communication efforts about the State incentive program to primary care physician practices. The MHCC plans to assess the impact of the State incentive program on EHR adoption and use in 2015, to determine whether other program enhancements may be needed.

A Strategy to Improve EHR Usability across Hospital Settings

Hospitals routinely identify a number of challenges for providers that use EHRs. Challenges in navigating EHR products have been discussed on a number of occasions at the federal level. Currently, federal guidelines regarding usability are not expected to be established for several years. To address concerns regarding the usability of EHRs and risk in care delivery, some states are considering EHR proficiency requirements as a part of physician licensure. For example, in Massachusetts, by 2015, physicians must demonstrate proficiency with EHRs as a condition of licensure.³⁰ An alternative approach to address EHR usability challenges is to build upon existing hospital training programs by establishing standards around training on hospital EHR systems.

In collaboration with stakeholders, establish a uniform EHR training curriculum for acute care hospitals.

Establishing consistent EHR training standards ensures that providers have sufficient knowledge of the EHR systems before using them as part of care delivery. Collaboration among stakeholders, such as members of the MHA, hospital CMIOs, CIOs, and Chief Technology Officers, is required to develop robust standards for an EHR training curriculum and facilitate an approach where hospitals may share current approaches and best practices in order to limit any duplication of effort regarding current training curriculums already in place. Part of developing a standard EHR training curriculum that outlines a specific set of core areas for training would include a method for assessing user familiarity with an EHR solution. Many hospitals are currently accredited to provide training courses that award providers continuing medical education units (CMEs), or continuing education units (CEUs). A uniform EHR training curriculum should include CME or CEUs for providers. Once developed, MHCC will also explore opportunities to share the EHR training curriculum with ambulatory provider groups where appropriate.

Remarks

For nearly a decade, the federal government and states have been implementing strategies aimed at transforming the way health information is managed, moving away from paper-based medical records to EHRs. The availability of incentives for EHR adoption at the federal level is a leading reason that providers have begun to move away from paper medical records. Restructuring Maryland's incentive program will encourage practice transformation by aligning it with the federal incentive program. Successful integration of EHRs is essential to creating an infrastructure needed

³⁰ Massachusetts Senate Bill 2863, *An Act to Promote Cost Containment, Transparency and Efficiency in the Delivery of Quality Health Care*, 2008. "The board shall require, as a standard of eligibility for licensure, that applicants show a predetermined level of competency in the use of computerized physician order entry, e-prescribing, electronic health records and other forms of health information technology, as determined by the board."

to provide fully interconnected and complete information about a patient at the point of care. In 2014, MHCC anticipates promulgating changes to the State incentive program regulations and working with acute care hospitals to develop a standard EHR training curriculum for providers.

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Appendix A: Md. Code Ann., Health-Gen. § 19-143

Md. HEALTH-GENERAL Code Ann. § 19-143

Annotated Code of Maryland

*** Current through all Chapters Effective October 1, 2012, of the 2012 General Assembly Regular Session, First Special Session, and Second Special Session. ***

HEALTH - GENERAL

TITLE 19. HEALTH CARE FACILITIES

SUBTITLE 1. HEALTH CARE PLANNING AND SYSTEMS REGULATION

PART IV. ELECTRONIC HEALTH RECORDS -- REGULATION AND REIMBURSEMENT

Md. HEALTH-GENERAL Code Ann. § 19-143 (2012)

§ 19-143. Electronic health records

(a) Designation of health information exchange. -- On or before October 1, 2009, the Commission and the Health Services Cost Review Commission shall designate a health information exchange for the State.

(b) Progress report. -- On or before January 1, 2010, the Commission shall:

(1) Report, in accordance with § 2-1246 of the State Government Article, to the Senate Finance Committee and the House Health and Government Operations Committee on progress in implementing the requirements of subsections (a) and (d) of this section; and

(2) Include in the report recommendations for legislation specifying how incentives required for State-regulated payors that are national carriers shall take into account existing carrier activities that promote the adoption and meaningful use of electronic health records.

(c) Subsequent report for review and comment. --

(1) On or before January 1, 2011, following consultations with appropriate stakeholders, the Commission shall post on its website for public comment and submit to the Governor and, in accordance with § 2-1246 of the State Government Article, the Senate Finance Committee and the House Health and Government Operations Committee a report on:

(i) The development of a coordinated public-private approach to improve the State's health information infrastructure;

(ii) Any changes in State laws that are necessary to protect the privacy and security of health information stored in electronic health records or exchanged through a health information exchange in the State;

(iii) Any changes in State laws that are necessary to provide for the effective operation of a health information exchange;

(iv) Any actions that are necessary to align funding opportunities under the federal American Recovery and Reinvestment Act of 2009 with other State and private sector initiatives related to health information technology, including:

1. The patient-centered medical home;
2. The electronic health record demonstration project supported by the federal Centers for Medicare and Medicaid Services;
3. The health information exchange; and
4. The Medicaid Information Technology Architecture Initiative; and

(v) Recommended language for the regulations required under subsection (d) of this section.

(2) The Senate Finance Committee and the House Health and Government Operations Committee shall have 60 days from receipt of the report for review and comment.

(d) Regulations; legislative intent. –

(1) On or before September 1, 2011, the Commission, in consultation with the Department, payors, and health care providers, shall adopt regulations that require State-regulated payors to provide incentives to health care providers to promote the adoption and meaningful use of electronic health records.

(2) Incentives required under the regulations:

- (i) Shall have monetary value;
- (ii) Shall facilitate the use of electronic health records by health care providers in the State;
- (iii) To the extent feasible, shall recognize and be consistent with existing payor incentives that promote the adoption and meaningful use of electronic health records;

(iv) Shall take into account:

1. Incentives provided to health care providers under Medicare and Medicaid; and
2. Any grants or loans that are available to health care providers from the federal government;

(v) May include:

1. Increased reimbursement for specific services;
2. Lump sum payments;
3. Gain-sharing arrangements;
4. Rewards for quality and efficiency;
5. In-kind payments; and
6. Other items or services to which a specific monetary value can be assigned; and

(vi) Shall be paid in cash, unless the State-regulated payor and the health care provider agree on an incentive of equivalent value.

(3) The regulations need not require incentives for the adoption and meaningful use of electronic health records, for each type of health care provider listed in § 19-142(e) of this subtitle.

(4) If federal law is amended to allow the State to regulate payments made by entities that self-insure their health benefit plans, regulations adopted under this section shall apply to those entities to the same extent to which they apply to State-regulated payors.

(5) Regulations adopted under this subsection:

(i) May not require a group model health maintenance organization, as defined in § 19-713.6 of this title, to provide an incentive to a health care provider who is employed by the multispecialty group of physicians under contract with the group model health maintenance organization; and

(ii) Shall allow a State-regulated payor to:

1. Request information from a health care provider to validate the health care provider's incentive claim; and

2. If the State-regulated payor determines that a duplicate incentive payment or an overpayment has been made, reduce the incentive amount.

(6) The Commission may:

(i) Audit the State-regulated payor or the health care provider for compliance with the regulations adopted under this subsection; and

(ii) If it finds noncompliance, request corrective action.

(7) It is the intent of the General Assembly that the State Employee and Retiree Health and Welfare Benefits Program support the incentives provided under this subsection through contracts between the Program and the third party administrators arranging for the delivery of health care services to members covered under the Program.

(e) Actions to ensure compliance with federal law. -- The Health Services Cost Review Commission, in consultation with hospitals, payors, and the federal Centers for Medicare and Medicaid Services, shall take the actions necessary to:

(1) Assure that hospitals in the State receive the payments provided under § 4102 of the federal American Recovery and Reinvestment Act of 2009 and any subsequent federal rules and regulations; and

(2) Implement any changes in hospital rates required by the federal Centers for Medicare and Medicaid Services to ensure compliance with § 4102 of the federal American Recovery and Reinvestment Act of 2009 and any subsequent federal rules and regulations.

(f) Mechanism for receipt of payments for participants in State medical assistance program. -- The Department, in consultation with the Commission, shall develop a mechanism to assure that health care providers that participate in the Maryland Medical Assistance Program receive the payments provided for adoption and use of electronic health records technology under § 4201 of the federal American Recovery and Reinvestment Act of 2009 and any subsequent federal rules and regulations.

(g) Report to Governor and General Assembly. -- On or before October 1, 2012, the Commission shall report to the Governor and, in accordance with § 2-1246 of the State Government Article, the General Assembly on progress achieved toward adoption and meaningful use of electronic health records by health care providers in the State and recommendations for any changes in State laws that may be necessary to achieve optimal adoption and use.

(h) Designation of management service organization. –

(1) On or before October 1, 2012, the Commission shall designate one or more management service organizations to offer services throughout the State.

(2) The Commission may use federal grants and loans to help subsidize the use of the designated management service organizations by health care providers.

(i) Requirements of electronic health records. -- On and after the later of January 1, 2015, or the date established for the imposition of penalties under § 4102 of the federal American Recovery and Reinvestment Act of 2009:

(1) Each health care provider using an electronic health record that seeks payment from a State-regulated payor shall use electronic health records that are:

(i) Certified by a national certification organization designated by the Commission; and

(ii) Capable of connecting to and exchanging data with the health information exchange designated by the Commission under subsection (a) of this section; and

(2) The incentives required under subsection (d) of this section may include reductions in payments to a health care provider that does not use electronic health records that meet the requirements of paragraph (1) of this subsection.

HISTORY: 2009, ch. 689; 2011, chs. 380, 532, 533.

Appendix B: State Incentive Program Payments Summary

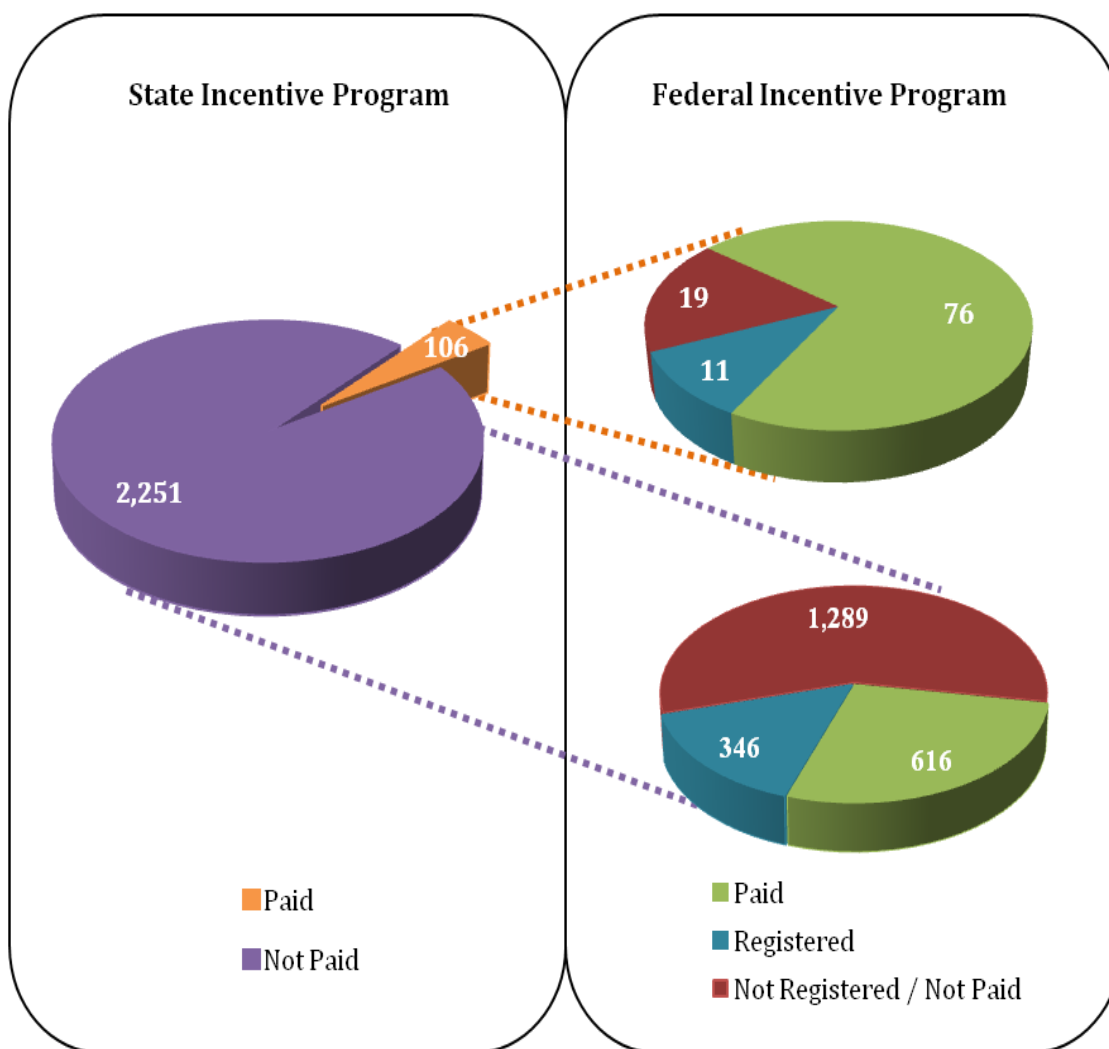
In accordance with Maryland law, payors must report annually to MHCC on the status of their implementation of the State incentive program. The MHCC asked payors to provide updated participation numbers for the incentive program through April 2013. Data indicates that the volume of payments made is fairly consistent across payors.³¹ Approximately four percent of primary care physician practices have received more than \$2.6 million in incentive payments. The following table provides a summary of payments by payor.

Incentive Program Payments Summary October 2011 – April 2013 <i>Eligible Practices = 2,349</i>					
Payor	Payments Made (#)	Total Base Incentive Amount Paid (\$)	Total Additional Incentive Amount Paid (\$)	Total Amount Paid (\$)	Average Incentive Amount (\$)
Aetna, Inc.	84	226,342	622,500	848,842	10,105
CareFirst BlueCross BlueShield	86	287,736	645,000	932,736	10,846
CIGNA Health Care Mid-Atlantic Region	80	25,288	6,124	31,412	393
Coventry Health Care	70	26,592	525,000	551,592	7,880
Kaiser Permanente	5	1,728	37,500	39,228	7,846
United Healthcare, MidAtlantic Region	85	123,792	123,792	247,584	2,913
Total	410	691,478	1,959,916	2,651,394	6,467
Total Unique Practices	106				
% of Eligible Practices	4				

³¹ Kaiser Permanente operates a closed managed care organization. COMAR 10.25.16 does not apply to managed care organizations. The majority of patients choose a primary care provider in the Kaiser Permanent network. Only practices outside of the Kaiser Permanente network are eligible for the program.

Appendix C: EHR Incentive Program Participation Status

The following chart provides an overview of the participation in the State and federal incentive programs among Maryland primary care physician practices.³² As of April 2013, approximately three percent of primary care physician practices have received payment under both the federal incentive program and the State incentive program. About 42 percent of those primary care physician practices that have not received payment under the State incentive program have either registered or received payment under the federal incentive program.



³² Primary care practice information calculated from Maryland Board of Physicians licensure data, 2011-2012. Maryland office-based and hospital-based primary care specialty practices include: family practice; general practice; internal medicine; pediatrics; and gynecology.

Appendix D: Summary of NCQA PCMH Standards

The table below is taken from NCQA's PCMH program documentation and provides an overview of the standards used to determine the level of recognition awarded to practices.³³

Standard	Content Summary
Enhance Access/Continuity	<ul style="list-style-type: none"> • Patients have access to culturally and linguistically appropriate routine/urgent care and clinical advice during and after office hours • The practice provides electronic access to their health information • Patients may select a clinician • The focus is on team-based care by trained staff
Identify/Manage Patient Populations	<ul style="list-style-type: none"> • The practice collects demographic and clinical data for population management • The practice assesses and documents patient risk factors • The practice identifies patients for proactive reminders
Plan/Manage Care	<ul style="list-style-type: none"> • The practice identifies patients with specific conditions, including high-risk or complex care needs and conditions related to health behaviors, mental health or substance abuse problems • Care management emphasizes: <ul style="list-style-type: none"> ○ Pre-visit planning ○ Assessing patient progress toward treatment goals ○ Addressing patient barriers to treatment goals • The practice reconciles patient medications at visits and post-hospitalization • The practice uses e-prescribing
Provide Self-Care Support/Community Resources	<ul style="list-style-type: none"> • The practice assesses patient/family self-management abilities • The practice works with patient/family to develop a self-care plan and provide tools and resources, including community resources • Practice clinicians counsel patients on healthy behaviors • The practice assesses and provides or arranges for mental health/substance abuse treatment
Track/Coordinate Care	<ul style="list-style-type: none"> • The practice tracks, follows-up on, and coordinates tests, referrals, and care at other facilities (e.g., hospitals) • The practice manages care transitions
Measure/Improve Performance	<ul style="list-style-type: none"> • The practice uses performance and patient experience data to continuously improve • The practice tracks utilization measures such as rates of hospitalizations and ER visits • The practice identifies vulnerable patient populations • The practice demonstrates improved performance

³³ The information contained within the table regarding PCMH program requirements originates from the *Standards and Guidelines for NCQA Patient-Centered Medical Home (PCMH) 2011* published by NCQA in 2011. The table was modified for the purposes of this report.

Appendix E: PCMH NCQA Requirements and Meaningful Use Crosswalk

The PCMH and MU programs have closely aligned health IT requirements. The following table provides a comparison of the MU Stage 1 requirements and the elements used to provide a practice with NCQA PCMH recognition.³⁴

MU	PCMH
Use computerized physician order entry (CPOE) for medication orders directly entered by any licensed health care professional who can enter orders into the medical record per State, local and professional guidelines	Enters electronic medication orders into the medical record for more than 30 percent of patients with at least one medication in their medication list
Implement drug-drug and drug-allergy interaction checks	Performs patient-specific checks for drug-drug and drug-allergy interactions
Maintain an up-to date problem list of current and active diagnoses	An up-to-date problem list with current and active diagnoses for more than 80 percent of patients
Generate and transmit permissible prescriptions electronically	Generates and transmits at least 40 percent of eligible prescriptions to pharmacies
Maintain active medication list	List of prescription medications with date of updates for more than 80 percent of patients
Maintain active medication allergy list	Allergies, including medication allergies and adverse reactions for more than 80 percent of patients
Record all of the following demographics: <ul style="list-style-type: none"> • Preferred language • Gender • Race • Ethnicity • Date of birth 	Record all of the following demographics: <ul style="list-style-type: none"> • Preferred language • Gender • Race • Ethnicity • Date of birth
Record and chart changes in the following vital signs: <ul style="list-style-type: none"> • Height • Weight • Blood pressure • Calculate and display: BMI • Plot and display growth charts for children 2–20 years, including BMI 	Record and chart changes in the following vital signs: <ul style="list-style-type: none"> • Height for more than 50 percent of patients 2 years and older • Weight for more than 50 percent of patients 2 years and older • Blood pressure, with the date of update for more than 50 percent of patients 2 years and older • System calculates and displays BMI (NA for pediatric practices) • System plots and displays growth charts

³⁴ The information contained within the table regarding PCMH program requirements originates from the *Standards and Guidelines for NCQA Patient-Centered Medical Home (PCMH) 2011* published by NCQA in 2011. The table was modified for the purposes of this report.

MU	PCMH
	(length/height, weight and head circumference (less than 2 years of age) and BMI percentile (2–20 years) (N/A for adult practices)
Record smoking status for patients 13 years old or older	Status of tobacco use for patients 13 years and older for more than 50 percent of patients
Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule	The practice implements evidence-based guidelines through point of care reminders for patients
Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies), upon request	More than 50 percent of patients who request an electronic copy of their health information (e.g., problem lists, diagnoses, diagnostic test results, medication lists and allergies) receive it within three business days
Provide clinical summaries for patients for each office visit	Clinical summaries are provided to patients for more than 50 percent of office visits within three business days
Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	The practice uses an EHR system (or modules) that has been certified and issued a Certified HIT Products List Number(s) under the ONC HIT certification program The practice attests to conducting a security risk analysis of its EHR system (or modules) and implementing security updates as necessary and correcting identified security deficiencies
Implement drug formulary checks (drug-drug, drug-allergy remain on core)	Alerts prescriber to formulary status
Incorporate clinical lab-test results into EHR as structured data	Electronically incorporates at least 40 percent of all clinical lab test results into structured fields in the medical record
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach	At least three different chronic or acute care services
Send reminders to patients per patient preference for preventive/follow up care	At least three different preventive care services
Provide patients with timely electronic access to health information (lab results, problem list, medication lists, allergies) within 4 business days of information being available to the EP	At least 10 percent of patients have electronic access to their current health information (including lab results, problem list, medication lists and allergies) within four business days of when the information is available to the practice
Use certified EHR to identify patient-specific education resources and provide if appropriate	Uses an EHR to identify patient-specific education resources and provide to more than 10 percent of patients, if appropriate
The EP who receives a patient from another setting of care or provider of care or believes an	Reviews and reconciles medications with patients/families for more than 50 percent of care

MU	PCMH
encounter is relevant should perform medication reconciliation	transitions
Provide summary care record for each transition of care and referral	<p>Providing an electronic summary of care record to another provider for more than 50 percent of referrals</p> <p>Provides an electronic summary-of-care record to another care facility for more than 50 percent of transitions of care</p>
Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice	Data to immunization registries or systems
Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice	Syndromic surveillance data to public health agencies

Appendix F: COMAR 10.25.16, Electronic Health Record Incentives

Title 10

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 25 MARYLAND HEALTH CARE COMMISSION

Chapter 16 Electronic Health Record Incentives

Authority: Health-General Article, §§19-103(c)(2)(i) and (ii), 19-109(a)(1), and

19-143(d)(1), (2), (3), and (4) and (i), Annotated Code of Maryland

10.25.16.01

.01 Scope.

A. This chapter applies to each payor that is required to provide incentive payments to each primary care practice that adopts and uses electronic health records, including those owned by a hospital.

B. Only a primary care practice that meets the requirements established in this chapter may receive an adoption incentive for electronic health record adoption under this program.

10.25.16.02

.02 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Additional incentive" means an adoption incentive not to exceed \$7,500 or an incentive of equivalent value above the base incentive awarded on a one-time basis to a primary care practice that meets additional criteria in the use and adoption of electronic health records including:

(a) Contracts with a management service organization for electronic health record adoption or implementation services;

(b) Demonstrates advanced use of electronic health records; or

(c) Participates in the payor's quality improvement outcomes initiative, and achieves the performance goals established by the payor.

(2) "Base incentive" means an adoption incentive not to exceed \$7,500 or an incentive of equivalent value awarded on a one-time basis to a primary care practice that is based on a per patient amount applied to the total number of the payor's member patients who are treated by the primary care practice.

(3) “Electronic health record (EHR)” means an electronic record system that is certified by an Authorized Testing and Certification Body designated by the Office of the National Coordinator for Health Information Technology and contains health-related information on an individual that:

(a) Includes patient demographic and clinical health information; and

(b) Has the capacity to:

(i) Provide clinical decision support;

(ii) Support physician order entry;

(iii) Capture and query information relevant to health care quality; and

(iv) Exchange electronic health information with and integrate the information from other sources.

(4) “EHR adoption incentive” means a cash payment or a payment incentive of equivalent value agreed upon by the primary care practice and payor that an eligible primary care practice can receive from a payor to assist the primary care practice in adopting and implementing an electronic health record.

(5) “EHR incentive application acknowledgement letter” means a letter sent by the payor to the primary care practice accepting the primary care practice’s EHR adoption incentive application.

(6) Health Care Provider.

(a) “Health care provider” means a person who is licensed, certified, or otherwise authorized under Health Occupations Article, Annotated Code of Maryland, to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program.

(b) “Health care provider” includes a facility where health care is provided to patients or recipients, including:

(i) A facility, as defined in Health-General Article, §10-101(e), Annotated Code of Maryland;

(ii) A hospital, as defined in Health-General Article, §19-301, Annotated Code of Maryland;

(iii) A related institution, as defined in Health-General Article, §19-301, Annotated Code of Maryland;

(iv) An outpatient clinic;

(v) A freestanding medical facility, as defined in Health-General Article, §19-3A-01, Annotated Code of Maryland;

(vi) An ambulatory surgical facility, as defined in Health-General Article, §19-3B-01, Annotated Code of Maryland; and

(vii) A nursing home, as defined in Health-General Article, §19-1401, Annotated Code of Maryland.

(c) "Health care provider" does not include a health maintenance organization as defined in Health-General Article, §19-701, Annotated Code of Maryland.

(7) "Incentive of equivalent value" means:

(a) Specific services;

(b) Gain-sharing arrangement;

(c) Rewards for quality and efficiency;

(d) In-kind payment; or

(e) Other items or services that can be assigned a specific monetary value.

(8) "Management service organization (MSO)" means an organization that offers one or more hosted electronic health record solutions and other management services to health care providers and:

(a) Has received recognition by the Maryland Health Care Commission as a State Designated MSO; or

(b) Has applied with the Maryland Health Care Commission for recognition as a State Designated MSO and has been granted Candidacy status.

(9) "MHCC or Commission" means the Maryland Health Care Commission.

(10) Payor.

(a) "Payor" means a State-regulated carrier that issues or delivers health benefit plans in the State and includes:

(i) Aetna, Inc;

(ii) CareFirst BlueCross BlueShield;

(iii) CIGNA HealthCare Mid-Atlantic;

(iv) Coventry Health Care;

(v) Kaiser Permanente;

(vi) United Healthcare, Mid-Atlantic Region; and

(vii) The state employee and retiree health and welfare benefits program.

(b) "Payor" does not include a managed care organization as defined in Health-General Article, Title 15, Subtitle 1, Annotated Code of Maryland.

(11) "Practice panel" means the patients assigned by a payor to a provider within a primary care practice or, when a payor does not assign patients to a provider within a primary care practice, the patients enrolled with that payor who have been treated by the primary care practice within the last 24 months.

(12) "Primary care practice" means a medical practice located in the State that is composed of one or more physicians who provide medical care in family, general, geriatric, internal medicine, pediatric, or gynecologic practice.

10.25.16.03

.03 Program Description.

A. An EHR adoption incentive shall be available to a primary care practice upon meeting the requirements set forth in Regulation .04 of this chapter.

B. A payor shall provide each primary care practice that applies for an EHR adoption incentive with a written description of the EHR adoption incentive to be provided by the payor and the timeframe for distribution of the EHR adoption incentive.

C. A payor may exclude from a primary care practice's base incentive calculation those payor's patient members who have been previously included in another primary care practice's base incentive calculation.

D. A primary care practice that has received an incentive under a payor-specific EHR adoption program before October 1, 2011, is only eligible to receive the difference between the value of the payor's prior incentive and the maximum value of the EHR adoption incentive under this chapter.

E. Upon written request by the primary care practice, a payor shall provide the primary care practice with documentation showing the total value of any incentive it provided under a payor-specific EHR adoption program prior to October 1, 2011.

F. A payor may:

(1) Request additional information from a primary care practice to validate the primary care practice's EHR adoption incentive payment request; and

(2) Reduce a remaining EHR adoption incentive to a primary care practice if the payor determines that a duplicate payment or an overpayment has been made under this chapter.

G. The MHCC may conduct audits to determine compliance with this chapter as follows:

(1) A payor shall cooperate with the MHCC's audit process;

(2) A primary care practice shall cooperate with the MHCC's audit process; and

(3) If an audit reveals noncompliance with this chapter, the MHCC may require corrective action.

H. This chapter shall also apply to an entity that self-insures its health benefit plans, if federal law is amended to allow state regulation of such EHR payments.

10.25.16.04

.04 Participation Requirements.

A. To be eligible for an EHR adoption incentive under this chapter, a primary care practice shall complete and submit an EHR adoption incentive application to each appropriate payor.

B. An EHR adoption incentive application shall include the following:

(1) Practice specific information:

(a) Name;

(b) Address;

(c) Specialty;

(d) Organizational national provider identifier number; and

(e) Tax identification number;

(2) The estimated total number of patients on the practice panel;

(3) The name and version of the nationally certified EHR system implemented by the primary care practice;

(4) Either a description of the EHR functions that the primary care practice has implemented or the estimated date the primary care practice expects to implement the available EHR system's functionality; and

(5) An attestation of the accuracy of the information contained in the application signed by an authorized member of the primary care practice.

C. A payor shall issue an EHR adoption incentive application acknowledgement letter as soon as is reasonably possible and no later than 90 days after receipt of an EHR adoption incentive application.

D. A primary care practice shall complete and submit an EHR adoption incentive payment request to each appropriate payor to receive an EHR adoption incentive, as follows:

(1) A primary care practice shall submit an EHR adoption incentive payment request no earlier than 6 months after submitting an EHR adoption incentive application to that payor but no later than December 31, 2014; and

(2) A primary care practice may request the additional incentive either with its request for the base incentive or in a subsequent EHR adoption incentive payment request.

E. The initial EHR adoption incentive payment request shall include the following:

- (1) A copy of the EHR incentive application acknowledgement letter;
- (2) A report that includes information identifying each member patient on its practice panel at the time of the request;
- (3) A description of how the primary care practice has achieved at least one of the additional incentive components described in Regulation .05(c) of this chapter for the past 90 days, if requesting the additional incentive; and
- (4) An attestation of the accuracy of the information contained in the application signed by an authorized member of the primary care practice.

F. Any subsequent EHR adoption incentive payment request for an additional incentive shall include a description of how the primary care practice has achieved at least one of the additional incentive components described in Regulation .05(c) of this chapter for the past 90 days, if requesting the additional incentive.

G. A payor may request additional information if necessary to validate an EHR adoption incentive payment request.

H. The calculation for a base incentive shall include the patients on the practice panel at the time the primary care practice submits the EHR adoption incentive payment request for the base incentive.

I. A payor shall process and pay in full the adoption incentive within 90 days of receiving an EHR adoption incentive payment request.

J. A payor shall notify a primary care practice in writing concerning the amount of the EHR adoption incentive requested, how the payor will distribute that EHR adoption incentive to the primary care practice, and the time period over which it will be distributed.

10.25.16.05

.05 Incentive Components.

A. A primary care practice that meets the requirements set forth in Regulation .04 of this chapter shall receive a base incentive from each payor that has member patients on the practice panel of that primary care practice.

B. A primary care practice shall receive an additional incentive if it demonstrates that it has achieved an additional incentive component during the immediate 90 days prior to submitting its EHR adoption incentive payment request.

C. An additional incentive component may include one of the following:

(1) A contract between the primary care practice and an MSO for EHR adoption or implementation services;

(2) A demonstration by the primary care practice of advanced use of an EHR system; or

(3) The participation by the primary care practice in a payor's quality improvement outcomes initiative and its achievement of the established performance goals.

D. Nothing in this chapter shall require a group model health maintenance organization to provide an incentive to a health care provider who is employed by a multispecialty group of physicians under contract with the group model health maintenance organization.

10.25.16.06

.06 Incentive Payment Calculation by Payor.

A. A primary care practice shall submit its adoption incentive application and any EHR adoption incentive payment request to each appropriate payor between October 1, 2011, and January 1, 2015.

B. An EHR adoption incentive is calculated at \$8 per member and limited to the payor's patient members who are Maryland residents.

C. The EHR adoption incentive consisting of a base incentive and any additional incentive shall have a maximum value of \$15,000 per practice per payor.

10.25.16.07

.07 Reporting.

A. A payor is required to submit an annual report to the MHCC for calendar years 2011 through 2014 no later than 90 days after the end of each calendar year.

B. The annual report shall include:

(1) The number of EHR adoption incentive applications received by the payor for that calendar year;

(2) The number of EHR adoption incentive payment requests received by the payor for that calendar year;

(3) The number of EHR adoption incentive payment requests processed by the payor for that calendar year;

(4) The total value of distributed base incentives for that calendar year; and

(5) The total value of additional incentives for that calendar year.

Administrative History

Effective date: May 16, 2011 (38:10 Md. R. 615)

Regulation .01 amended as an emergency provision effective October 21, 2011 (38:24 Md. R. 1495); amended permanently effective January 9, 2012 (38:27 Md. R. 1764)

Regulation .02B amended as an emergency provision effective October 21, 2011 (38:24 Md. R. 1495); amended permanently effective January 9, 2012 (38:27 Md. R. 1764)

Regulation .03 amended as an emergency provision effective October 21, 2011 (38:24 Md. R. 1495); amended permanently effective January 9, 2012 (38:27 Md. R. 1764)

Regulation .04 amended as an emergency provision effective October 21, 2011 (38:24 Md. R. 1495); amended permanently effective January 9, 2012 (38:27 Md. R. 1764)

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Regulation .06 amended as an emergency provision effective October 21, 2011 (38:24 Md. R. 1495); amended permanently effective January 9, 2012 (38:27 Md. R. 1764)

Regulation .07 amended as an emergency provision effective October 21, 2011 (38:24 Md. R. 1495); amended permanently effective January 9, 2012 (38:27 Md. R. 1764)



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